STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2011
	NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER		1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for State Licensure of State Licensure of State Licensure of State Licensure of Survey dates: In 12, 2011 Facility number: Provider number AIM number: 2d Survey team: Vicki Manuwal, Bobbie Costigan Census bed type SNF: 26 SNF/NF: 47 Total: 73 Census by payor Medicare: 26 Medicaid: 30 Other: 17 Total: 73 Sample: 15 These deficiencic cited in accordance of the state of the st	a Recertification and Survey. December 5, 6, 7, 8, 9, and 012329 155784 01002500 RN TC RN TC RN TC	F0000	DEFICIENCY	DATE
	Cathy Emswiller	-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11

Facility ID:

012329

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE (COMPL 12/12/2	ETED
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER			/AKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	+	TAG	Burelakery		DATE
F0167 SS=C	of the most recent conducted by Feddany plan of correct the facility. The facility must make the facility of the readily accessible a notice of their available and observe facility failed to were readily accessible at the facility of the facility. Findings include Observation on 1 survey book was During interview 12/8/11 at 3:00 P survey book from desk. She further kept behind the dwanted to see it, welcome to ask for Observation on 1 observation observation on 1 observation observation on 1 observation observation on 1 observation observation observation on 1 observation o	ation and interview, the ensure the survey results essible to residents and aving to ask a staff ve the survey book. This had the potential to esidents who reside in the esidents who reside in the exidents of exidents who reside in the exidents of exidents and exidents of exidents and exidents of exidents and exidents of exidents o	F016	67	F167It is the practice of this facility that a resident has the right to examine the results of most recent survey. CORRECTIVE ACTION The Survey Binder has been placed in the Library for easy access for Residents, Visitors Staff, Etc. Notice posted at Reception area indicating the Survey Binder is located in Library. HOW OTHERS IDENTIFIED: Everyone wanto view the binder will be addressed by placing the bin in the Library. PREVENTATION MEASURES: Administrator and/or designee will check placement of binder. MONITORING: Placement to be monitored of for 2 weeks, 3 times a weeks weeks, weekly for 8 weeks, a monthly for 3 months. All find will be reviewed at monthly of meeting. Any deficient practic be addressed through staff education, in-service, and/or counseling. ADDENDUM ADDED: COMPLIANCE DATE.	of the DN: s, st ting der /E ailly for 8 and dings QPI e will	01/09/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CON	ISTRUCTION 00	(X3) DATE S COMPL	
ANDIEM	or condition	155784	A. BUILDING	G		12/12/2	
			B. WING STI	REET AL	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OOUGLAS RD		
MICHIAN	A HEALTH AND RE	EHABILITATION CENTER	MI	ISHAW	/AKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	behind the recept	· · · · · · · · · · · · · · · · · · ·	171				DITTE
	•						
	-	on 12/9/11 at 11:10					
	•	onist indicated the survey					
	book is normally	kept behind the desk.					
	A sign indicating	the location of the					
		results was not posted at					
	any time during t	the above observations.					
	2 1 2(b)(1)						
	3.1-3(b)(1)						
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary			İ			
SS=D							
	seclusion.	,, ,					
	The facility must not use verbal, mental,						
	sexual, or physical	l abuse, corporal					
	•	oluntary seclusion. ew and record review, the	F0223		F223It is the practice of this		01/09/2012
		ensure residents were	10223		facility that residents will be fi	ree	01/09/2012
	•	erbal abuse by staff for 2			from verbal, sexual, physical,	and	
	•	d that residents were			mental abuse, corporal punishment, and involuntary		
	protected from pl	hysical abuse from staff			seclusion.CORRECTIVE		
	for 2 of 9 residen	its reviewed for abuse in			ACTION: Resident # 40 -		
	a sample of 15.	[CNA # 31 and CNA #			Resident is stable with no sig or symptoms of psychosocial		
	32] [Residents	#40, #30]			issues related to this		
					incident.Resident # 30 - Resi is stable with no signs or	dent	
	Findings include:	:			symptoms of psychosocial is:		
	1. The clinical record of Resident #40				related to this incident.Emplo involved in the incidents revie	-	
		12/06/2011 at 11:03 a.m.			during survey have been	-weu	
		agnoses include, but			terminated. Incidents were		
	resident 11-10 5 di	agnosco merade, out			reported to ISDH, Ombudsma	an,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 3 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155784 12/12/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1420 E DOUGLAS RD MICHIANA HEALTH AND REHABILITATION CENTER MISHAWAKA, IN46545 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE APS, and Law Enforcement as were not limited to, HTN (hypertension), indicated. Facility will continue to COPD (Chronic Obstructive Pulmonary follow Policy and Procedure Disease) and right sided heart failure. related to Abuse Prohibition.HOW OTHERS IDENTIFIED: Residents residing in facility will A "Concern Report" dated 11/12/11 be addressed by following Policy indicated, "... The first thing I heard this and Procedures and termination a.m. was Resident #40 telling me she does of employees not want CNA #31 taking care of her, she involved.PREVENTATIVE said CNA #31 was rude to her one time. MEASURES: Staff in-serviced on Abuse Prohibition Policy and Later on Resident #30 was leaving the Procedure to include proper dining room and said she had to potty I reporting per policy.ADDENDUM don't want the other girl she slammed me ADDED 1/4/12MONITORING: down into my chair. After second shift Administrator and/or designee will continue to follow up on all came in another resident started saying allegations of abuse immediately. she heard them in the bathroom (Resident An Incident and Accident form will #30 and the aid (sic)) and said Resident be completed on any allegation of abuse and will be followed up by #30 was saying things like owe (sic), stop Administrator and/or designee it that hurts, and she wished she could get immediately per policy. All out of that bed and go in there...." Incident and Accident forms are reviewed daily at morning An unlabeled form dated 11/14/11 meeting. Monitoring will continue on an indefinite basis per policy. indicated, "Interview with Resident #40-All concern forms will continue to Resident states that CNA #31 is very rude be reviewed daily. All findings will and she does not care for her. Resident be reviewed at monthly QPI further states that if CNA #31 answers her meeting. Any deficient practice will be addressed through staff call light she instructs her to "go get education, in-service, and/or someone to help me."...." counseling. An unlabeled form dated 11/18/11 at 4:00 p.m. indicated, "Employee stated she has never been abusive to a resident. She further stated that she was rushing a resident Sunday (11/13/11) to put her on the toilet and "flew out of the room" to

012329

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	LDING	NSTRUCTION 00	r í	ESURVEY LETED 2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET A 1420 E I	DDRESS, CITY, STATE, ZIP COE DOUGLAS RD VAKA, IN46545	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	toiletingEmplo doesn't say much she does not war resident's room to employee stated allegation because certification for been rude or abu Employee furthe had an argument employee, CNA stated that CNA confrontational a words to her unle employee was not employee with whad an altercation with whom the country to have taken plass to have taken	r stated that she has never or altercation with #32. This employee #32 is very lazy and and she doesn't say 2 (sic) ess she has to. The set told the name of the strong is was reported she in; (sic) yet, she knew confrontation was alleged in it in the properties of t				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11

Facility ID:

012329

If continuation sheet

Page 5 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	NSTRUCTION 00	(X3) DATE COMPI 12/12/2	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	11/18/11 for CN. "Specify work ect., violated- Vi not reporting per profanity/alterca Described what I alleged abuse to to notify HFA (A instead, wrote a reviewed 11/14/ altercation with a nursing station w profanityDiscip taken:Discharg The "Disciplinar 11/18/11 for CN "Specify work ect., violated- Vi Describe what ha residents alleged abusive. Investig allegation of abu argument /alterca member at nurse residents and sta being taken:Di employment11 to sign(CNA # WITH THIS, I H	rule, policy, standard, olation of Abuse Policy-policy. Use of tion in Resident area. happened- Residents this employee who failed administrator)/DON; but concern form which was 11. Employee engaged in another employee at which included plinary action being the from employment" y Action Report" dated A #31 indicated, rule, policy, standard, olation of Abuse Policy. Appened- Multiple this employee was gation substantiated see. Employee had action with another staff is station in front of ffDisciplinary action					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L			DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			NAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG			+	TAG	DEFICIENCT)		DATE
		ecord of Resident #30					
		12/7/2011 at 12:55 p.m.					
		iagnoses include, but					
		to, HTN (hypertension)					
	and CHF (conge	stive heart failure)					
	_	ort" dated 11/12/11					
	· · · · · · · · · · · · · · · · · · ·	e first thing I heard this					
		nt #40 telling me she does					
		31 taking care of her, she					
		as rude to her one time.					
		at #30 was leaving the					
	_	said she had to potty I					
		her girl she slammed me					
	down into my ch	air. After second shift					
		resident started saying					
	she heard them is	n the bathroom (Resident					
	#30 and the aid (sic)) and said Resident					
	#30 was saying t	hings like owe (sic), stop					
	it that hurts, and	she wished she could get					
	out of that bed ar	nd go in there"					
	An unlabeled for	rm dated 11/14/11 at					
		ated, "Interview with					
		esident #30 stated that					
		gh and slammed her into					
	· ·	fter taking her to the					
		lunch on Saturday					
		nat she did not want her					
		bathroom ever again.					
		pesn't want to get anyone					
		e does not want her					
	helping her any i	HOLE (SIC)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X	(2) MULTIPLE				(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155784	A	. BUILDING	_	00		12/12/2	
		150704	В.	. WING				12/12/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹				RESS, CITY, STAT	E, ZIP CODE		
MICHIAN		EHABILITATION CENTER				UGLAS RD KA, IN46545			
					IAVVAI	NA, IIN40545			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FUL	,	ID PREFIX		PROVIDER'S PLA	IN OF CORRECTION		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATIO		TAG	C	CROSS-REFERENCED DEFICE	TO THE APPROPRIAT	E	DATE
		rm dated 11/18/11 at 4:00							5.112
		Employee stated she has							
	_	ive to a resident. She							
		at she was rushing a							
		(11/13/11) to put her on							
	1	ew out of the room" to							
		sident who needed							
		byee stated that she							
		n to the residents because							
	1	nt to be "stuck" in a							
		alking to themThe							
		she would "fight" this							
		se she has had her							
		19 years and has not ever							
	been rude or abu								
		er stated that she has never	r						
	1	t or altercation with							
	_	#32. This employee							
		#32 is very lazy and							
		and she doesn't say 2 (sic)	,						
		ess she has to. The							
		ot told the name of the							
		whom is was reported she							
		on; (sic) yet, she knew							
		confrontation was alleged							
	to have taken pla	-							
	F								
	The "Disciplinar	ry Action Report" dated							
		A #32 indicated,							
		rule, policy, standard,							
		ilure to report allegation							
		J/Administrator. Describe	e						
		On 11/14/11, ADON							
		report alleging another							
FORM CMS-2	567(02-99) Previous Version	-	D: SB4	V11 Facil	ity ID:	012329	If continuation sh	neet Pag	ge 8 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIEF				DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER		MISHAV	VAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		ve to Resident #40 and		TAG			DATE
		ON and Administrator					
		one employee (alleged					
		eation thru 11/18/11. This					
	employee is susp						
	investigation"	venuou ponumg					
	The "Disciplinar	y Action Report" dated					
	11/18/11 for CN						
	"Specify work	rule, policy, standard,					
	ect., violated- Vi	olation of Abuse Policy-					
	not reporting per	policy. Use of					
	profanity/alterca	tion in Resident area.					
	Described what l	happened- Residents					
	alleged abuse to	this employee who failed					
	to notify HFA (A	Administrator)/DON; but					
	instead, wrote a	concern form which was					
		11. Employee engaged in					
		another employee at					
	nursing station w						
	1 .	plinary action being					
	taken:Discharg	ge from employment"					
	The "Disciplinar	y Action Report" dated					
	11/18/11 for CN	A #31 indicated,					
	"Specify work	rule, policy, standard,					
	ect., violated- Vi	olation of Abuse Policy.					
	Describe what ha	appened- Multiple					
	residents alleged	this employee was					
		gation substantiated					
	allegation of abu	se. Employee had					
	argument /alteres	ation with another staff					
		s station in front of					
	residents and sta	ffDisciplinary action					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	NSTRUCTION 00	(X3) DATE (COMPL 12/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	•			DDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	being taken:Di	_					
	1 1	/18/11 employee refused					
	,	31) I do NOT AGREE IAVE NEVER ABUSED					
	•	A #31 signature)"					
	`	ecord for Resident # 1					
		5/11 at 3:00 P.M.,					
		ses of, but not limited to:					
	cerebrovascular	accident, hemiplegia, and					
	arthritis.						
	Review of a "Fac	cility Incident Reporting					
		"Incident Date:					
		ent, (Name), reported to a					
		tursing aide) that she did					
	,	A (CNA # 31) who had					
	cared for her dur	ing the day shift to care					
	for her any more	(sic). The resident stated					
		ike this CNA (CNA # 31)					
		ery rude and rough with					
		explained that (Name,					
	· ·	vays in a hurry when she					
		the pulls on her left arm					
		The resident states that ame, CNA # 31) to be					
	`	y times and that she					
		begins to sing songs.					
	_	31) alleges that when					
	, ,	dent to stand, the CNA					
	_	er to stand; but, she					
	reaches under he	r arms and lifts her up					
	and throws her in	n her chairCNA					
		(1) was immediately					
	suspended pendi	ng investigationThe					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 10 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMP: 12/12/2	LETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	b. WINC	STREET A 1420 E I	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	allegation was su (CNA # 31) was	bstantiated and the CNA terminated"					
	and Director of N 6:10 P.M., they is their facility polisterminated the erabuse was substanced. Review of a facility Prevention and Mistreatment, No Injuries of Unknown Misappropriation dated October 19:2010, indicated "Services, Inc. (Examistreatment, near residents and misproperty by anyon family, friends, ewritten, or gesturd disparaging and cresident or their shearing distance, regardless of their comprehend or dincludes hitting,	ity policy titled Reporting: Resident eglect, Abuse, Including own Source, and n of Resident Property", 199, revised last JulyExtendicare Health HSI) prohibits the glect, and abuse of sappropriation of resident one including staff, ttcVerbal abuse is oral, red language that includes derogatory terms to the families or within their to describe residents,					
	3.1-27(a)(1) 3.1-27(b)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2011
NAME OF I	PROVIDER OR SUPPLIEF	2	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
MICHIANA HEALTH AND REHABILITATION CENTER				E DOUGLAS RD NWAKA, IN46545	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784			(X2) MULTII A. BUILDING B. WING		OO	(X3) DATE (COMPL 12/12/2	ETED
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	ST1	20 E D	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
F0225 SS=D	The facility must in have been found gor mistreating resident have had a finding nurse aide registry mistreatment of resident of their property; a has of actions by a employee, which we service as a nurse the State nurse aide authorities. The facility must eviolations involving abuse, including ir and misappropriat reported immediate the facility and to with State law through (including to the Sagency). The facility must halleged violations and must prevent the investigation is the results of all in reported to the addrepresentative and accordance with State survey and oworking days of the	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or a entered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing Insure that all alleged guistreatment, neglect, or nijuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated it to other officials in that law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					
	Based on record facility failed to was immediately of verbal abuse b	review and interview, the ensure the Administrator notified of an allegation	F0225		F225It is the practice of this facility that all alleged violatio involving mistreatment, negle or abuse, including injuries of unknown source and misappropriation of resident	ect,	01/09/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	155784		LDING	00	12/12/20	
		100704	B. WIN	_		12/12/20	311
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
		TATEMENT OF DEFICIENCIES	1	ID ID			(7/5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	of 15 [CNA#3	1 and CNA # 32]			property are reported immed	iatelv	
	[Resident # 30, #	-			to the administrator of the fac		
	[Resident # 50, #	40]			and to other officials in		
	Findings include				accordance with State law		
	Tilldings illetude	•			through established procedu (including the State survey a		
	1 701 1: 1	1 CD :1 4 #40			certification	iiu	
		ecord of Resident #40			agency).CORRECTIVE ACT	ION:	
		12/06/2011 at 11:03 a.m.			ADDENDUM ADDED		
		iagnoses include, but			1/4/12Resident # 40 - Reside		
		to, HTN (hypertension),			stable with no signs or sympostorial of psychosocial issues relate		
	,	Obstructive Pulmonary			this incident.Resident # 30 -	iu io	
	Disease) and right	nt sided heart failure.			Resident is stable with no sig	gns	
					or symptoms of psychosocia		
	A "Concern Rep	ort" dated 11/12/11			issues related to this		
	indicated, "The	e first thing I heard this			incident.Employees involved		
	a.m. was Resider	nt #40 telling me she does			the incidents reviewed during survey have been terminated	- 1	
	not want CNA #	31 taking care of her, she			Incidents were reported to IS		
	said CNA #31 w	as rude to her one time.			Ombudsman, APS, and Law		
	Later on Resider	nt #30 was leaving the			enforcement as indicated.		
		said she had to potty I			Facility will continue to follow		
	_	her girl she slammed me			Policy and Procedures relate Abuse Prohibition.HOW OTH		
		air. After second shift			IDENTIFIED: Residents resi		
	_	resident started saying			in facility will be addressed b	-	
		n the bathroom (Resident			following Policy and Procedu		
		(sic)) and said Resident			and the termination of emplo involved.PREVENTATIVE	yees	
		hings like owe (sic), stop			MEAURES: Staff in-serviced	d on	
		she wished she could get			Abuse Prohibition Policy and		
	out of that bed a	_			Procedure to include proper		
	out of that bed at	nd go iii tilere			reporting per		
	An unlabalad far	m dated 11/14/11			policy.MONITORING:	اانید د	
					Administrator and/or designe continue to follow up on	e WIII	
	· ·	view with Resident #40-			allegations of abuse immedia	ately.	
		hat CNA #31 is very rude			Concern forms will continue	to be	
		care for her. Resident			reviewed daily. All findings v	vill be	
		t if CNA #31 answers her			reviewed at monthly QPI	اانید در	
	call light she inst	tructs her to "go get			meeting.Any deficient practic	C WIII	

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED
NAME OF PROVIDER (JB SHIDDI IED				ADDRESS, CITY, STATE, ZIP CODE		
					DOUGLAS RD		
		EHABILITATION CENTER		MISHAV	NAKA, IN46545		
` ′		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	ne to help	<u> </u>		1710	be addressed through staff		DATE
Someon	ic to neip				education, in-service, and/or		
An unl	abeled for	m dated 11/18/11 at 4:00			counseling.		
		Employee stated she has					
	never been abusive to a resident. She						
further	stated tha	t she was rushing a					
residen	t Sunday	(11/13/11) to put her on					
the toil	et and "flo	ew out of the room" to					
assist a	nother res	sident who needed					
		yee stated that she					
	-	to the residents because					
		nt to be "stuck" in a					
		alking to themThe					
		she would "fight" this					
_		se she has had her					
		19 years and has not ever					
		sive to anyone.					
		r stated that she has never					
	•	or altercation with					
1	-	#32. This employee					
		#32 is very lazy and					
		and she doesn't say 2 (sic)					
		ess she has to. The					
		ot told the name of the whom is was reported she					
		n; (sic) yet, she knew					
		onfrontation was alleged					
	taken pla	•					
lonave	tunen più						
The "D	isciplinar	y Action Report" dated					
	-	A #32 indicated,					
		rule, policy, standard,					
_	-	ilure to report allegation					
		/Administrator. Describe					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 15 of 73

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X	(2) MULT	IPLE CON	NSTRUCTION		(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155784	A.	. BUILDIN	IG	00		12/12/2	
		150704	В.	WING				12/12/2	011
NAME OF F	PROVIDER OR SUPPLIER	₹				DDRESS, CITY, STA	ATE, ZIP CODE		
MAICHIAN						OUGLAS RD			
		EHABILITATION CENTER		IV	IISHAW	/AKA, IN46545			
(X4) ID		TATEMENT OF DEFICIENCIES		II			LAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL			FIX	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1)	17	AG	DEF	ICIENCI)		DATE
	* *	On 11/14/11, ADON							
		report alleging another							
		ve to Resident #40 and							
		ON and Administrator							
		One employee (alleged							
	· ·	eation thru 11/18/11. This							
ļ	employee is susp								
	investigation"								
	•	y Action Report" dated							
	11/18/11 for CN.								
		rule, policy, standard,							
		iolation of Abuse Policy-							
	not reporting per	policy. Use of							
	profanity/altercat	tion in Resident area.							
	Described what h	happened- Residents							
	alleged abuse to	this employee who failed							
	to notify HFA (A	Administrator)/DON; but							
	instead, wrote a	concern form which was							
	reviewed 11/14/1	11. Employee engaged in							
ļ	altercation with a	another employee at							
	nursing station w	which included							
	profanityDiscit	plinary action being							
		ge from employment"							
		• •							
	The "Disciplinar	y Action Report" dated							
	11/18/11 for CN.	A #31 indicated,							
	"Specify work	rule, policy, standard,							
		iolation of Abuse Policy.							
ļ		appened- Multiple							
	residents alleged this employee was								
	abusive. Investigation substantiated								
		ise. Employee had							
	_	ation with another staff							
FORM CMS-2	567(02-99) Previous Version		SB4\	\/11	Facility II	D: 012329	If continuation sh	eet Da	ge 16 of 73

i f		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE		
					DOUGLAS RD		
		EHABILITATION CENTER		<u> </u>	NAKA, IN46545		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	residents and sta	s station in front of ffDisciplinary action					
	being taken:Discharge from employment11/18/11 employee refused to sign(CNA #31) I do NOT AGREE						
	,	IAVE NEVER ABUSED					
		A #31 signature)"					
	Ì	- /					
		ecord of Resident #30					
		12/7/2011 at 12:55 p.m.					
		iagnoses include, but					
		to, HTN (hypertension)					
	and CHF (conge	stive heart failure)					
	A "Concern Rep	ort" dated 11/12/11					
	•	e first thing I heard this					
		nt #40 telling me she does					
		31 taking care of her, she					
	said CNA #31 w	as rude to her one time.					
	Later on Resider	nt #30 was leaving the					
	_	said she had to potty I					
		her girl she slammed me					
		air. After second shift					
		resident started saying					
		n the bathroom (Resident					
	· · · · · · · · · · · · · · · · · · ·	(sic)) and said Resident					
		things like owe (sic), stop					
	out of that bed an	she wished she could get					
	out of that bed al	na go in mere					
	An unlabeled for	m dated 11/14/11 at					
	10:45 a.m. indica	ated, "Interview with					
	Resident #30- Re	esident #30 stated that					
	CNA #31 is roug	gh and slammed her into					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 17 of 73

		X1) PROVIDER/SUPPLIER/CLIA	(X	(2) MULTI	PLE CON	STRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A.	BUILDIN	G	00		COMPL	
		155784		WING				12/12/2	011
NAME OF F	PROVIDER OR SUPPLIE		<u> </u>	ST	REET AD	DDRESS, CITY, STA	TE, ZIP CODE		
						OUGLAS RD			
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER		M	ISHAW	'AKA, IN46545			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			AN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PRE		CROSS-REFERENCEI	E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TA	.G	DEFIC	CIENCY)		DATE
		after taking her to the							
		e lunch on Saturday							
		hat she did not want her							
		e bathroom ever again.							
		oesn't want to get anyone							
		e does not want her							
	helping her any	more (sic)"							
	An unlabeled for	rm dated 11/18/11 at 4:00							
	p.m. indicated, "	'Employee stated she has							
	*	ive to a resident. She							
		at she was rushing a							
		(11/13/11) to put her on							
	_	ew out of the room" to							
		sident who needed							
		oyee stated that she							
		h to the residents because							
	_	nt to be "stuck" in a							
		talking to themThe							
		she would "fight" this							
		se she has had her							
	_	19 years and has not ever							
	been rude or abu								
		er stated that she has never							
		t or altercation with							
	_	#32. This employee							
		#32 is very lazy and							
		and she doesn't say 2 (sic)							
		ess she has to. The							
		ot told the name of the							
	1	whom is was reported she							
		on; (sic) yet, she knew							
		confrontation was alleged							
	to have taken pla								
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	SB4\	V11 I	Facility ID	012329	If continuation sh	eet Pa	ge 18 of 73

Page 18 of 73

i '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED
NAME OF I	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER		DOUGLAS RD VAKA, IN46545		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORT OR	ESC IDENTIF TINO INFORMATION)	TAG			DAIL
	The "Disciplinar	y Action Report" dated				
		A #32 indicated,				
		rule, policy, standard,				
		ilure to report allegation				
		//Administrator. Describe				
		On 11/14/11, ADON				
		report alleging another to Resident #40 and				
		ON and Administrator				
		one employee (alleged				
		eation thru 11/18/11. This				
	employee is susp					
	investigation"	1 0				
	_	y Action Report" dated				
		A #32 indicated,				
		rule, policy, standard,				
		olation of Abuse Policy-				
	not reporting per	1 2				
		tion in Resident area. happened- Residents				
		this employee who failed				
	_	Administrator)/DON; but				
		concern form which was				
	•	11. Employee engaged in				
		another employee at				
	nursing station w	which included				
		plinary action being				
	taken:Discharg	ge from employment"				
	The "Disciplinar	y Action Report" dated				
		A #31 indicated,				
		rule, policy, standard,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 19 of 73

AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	ĺ	LDING	NSTRUCTION 00	(X3) DATE (COMPL 12/12/2	ETED
NAME OF	PROVIDER OR SUPPLIEF	•			DDRESS, CITY, STATE, ZIP CODE		
MICHIA	NA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Describe what has residents alleged abusive. Investigallegation of abusing argument /alterest member at nurse residents and state being taken:Disemployment11 to sign(CNA #WITH THIS, I FANYONE. (CN Review of a faci "Prevention and Mistreatment, Nanyuries of Unkn Misappropriation dated October 19 2010, indicated 'Services, Inc. (Emistreatment, neresidents and misproperty by anyufamily, friends, of facilities to report to the Administration is assurance of this assurance of this	/18/11 employee refused 31) I do NOT AGREE IAVE NEVER ABUSED A #31 signature)" lity policy titled Reporting: Resident eglect, Abuse, Including own Source, and n of Resident Property", 299, revised last July					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 20 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2011
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STRE 1420	ET ADDRESS, CITY, STATE, ZIP CODE DE DOUGLAS RD HAWAKA, IN46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	to the resident or their hearing dist residents, regard comprehend or d includes hitting, scratching, spitting etc" During interview Administrator or the Administrator expected to follo	less of their age, ability to disabilityPhysical abuse slapping, pinching, ang, holding roughly, with the facility a 12/6/11 at 6:15 P.M., or indicated staff were with the facility policy and ling reporting and			
F0226 SS=D	written policies an mistreatment, neg and misappropriat	levelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. review, the facility failed ministrator was	F0226	F226It is the practice of this facility to develop and impler written policies and procedu	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE COMPL	
ANDIEM	or conduction	155784		LDING		12/12/2	
		100704	B. WIN			12/12/2	011
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			NAKA, IN46545		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	immediately not	ified of an allegation of			that prohibit mistreatment,		
	verbal abuse by	staff for 1 of 9 residents			neglect, and abuse of reside		
	reviewed for abuse in a sample of 15. [CNA # 31 and CNA # 32] [Resident #				and misappropriation of reside property.CORRECTIVE	Jeni	
					ACTION:Resident # 40 - Res	sident	
	30, # 40]				is stable with no signs or		
					symptoms of psychosocial is		
	Findings include	:			related to this incident.Residented 30 - Resident is stable with n		
					signs or symptoms of		
	1. The clinical re	ecord of Resident #40			psychosocial issues related t		
	was reviewed on	12/06/2011 at 11:03 a.m.			this incident.Employees invo		
	Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary				in the incidents reviewed dur survey have been terminated	•	
					Incidents were reported to IS		
					Ombudsman, APS, and Law		
	Disease) and right	ht sided heart failure.			Enforcement as indicated.		
					Facility will continue to follow		
	A "Concern Ren	ort" dated 11/12/11			Policy and Procedures relate Abuse Prohibition.HOW OTH		
	_	e first thing I heard this			IDENTIFIED: Residents resi		
	· ·	nt #40 telling me she does			in facility will be addressed b	•	
		31 taking care of her, she			following Policy and Procedu		
		ras rude to her one time.			and termination of employee	S	
					involved.PREVENTATIVE MEASURES: Staff in-service	od on	
		nt #30 was leaving the			Abuse Prohibition Policy and		
	_	said she had to potty I			Procedure to include proper		
		her girl she slammed me			reporting per policy.ADDEND		
	1	nair. After second shift			ADDED 1/4/12MONITORING		
		resident started saying			Administrator and/or designe	e will	
		n the bathroom (Resident			continue to follow up on allegations of abuse		
		(sic)) and said Resident			immediately. An Incident and	d	
		things like owe (sic), stop			Accident form will be comple		
	it that hurts, and	she wished she could get			on any allegation of abuse a	nd	
	out of that bed as	nd go in there"			will be followed up by		
					Administrator and/or designe immediately per policy. All	ee	
	An unlabeled for	rm dated 11/14/11			Incident and Accident forms	are	
	indicated, "Interv	view with Resident #40-			reviewed daily at morning	-	
	-	hat CNA #31 is very rude			meeting. Monitoring will con	tinue	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL		
		155784	A. BUII B. WIN			12/12/2	011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		1420 E I	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
IAU	and she does not further states that call light she inst someone to help An unlabeled for p.m. indicated, "I never been abusi further stated that resident Sunday the toilet and "fle assist another restoiletingEmplo doesn't say much she does not wan resident's room to employee stated allegation because certification for a been rude or abuse Employee further had an argument employee, CNA stated that CNA confrontational a words to her unle employee was not employee with whad an altercation with whom the count of the to have taken plants.	care for her. Resident t if CNA #31 answers her tructs her to "go get me."" m dated 11/18/11 at 4:00 Employee stated she has ve to a resident. She t she was rushing a (11/13/11) to put her on ew out of the room" to ident who needed yee stated that she t to the residents because it to be "stuck" in a alking to themThe she would "fight" this se she has had her 19 years and has not ever sive to anyone. r stated that she has never or altercation with #32. This employee #32 is very lazy and and she doesn't say 2 (sic) ess she has to. The of told the name of the whom is was reported she in; (sic) yet, she knew onfrontation was alleged ce."		IAU	on an indefinite basis per pol Concern forms will continue reviewed daily. All findings v reviewed at monthly QPI meeting. Any deficient practic be addressed through staff education, in-service, and/or counseling.	to be vill be	DATE
	11/14/11 101 CN	A #32 IIIUICAICU,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 23 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
155784		155784	A. BUI B. WIN	LDING IG		12/12/2	011
NAME OF I	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	TANA, INTODES		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	15	DATE
	1 -	rule, policy, standard,					
	1	ilure to report allegation					
		/Administrator. Describe On 11/14/11, ADON					
		report alleging another					
		re to Resident #40 and					
		ON and Administrator					
	were notified. O	ne employee (alleged					
	· /	ation thru 11/18/11. This					
	employee is susp	ended pending					
	investigation"						
	The "Disciplinar	y Action Report" dated					
	11/18/11 for CN	•					
		rule, policy, standard,					
		olation of Abuse Policy-					
	not reporting per	policy. Use of					
	1 *	tion in Resident area.					
		nappened- Residents					
	"	this employee who failed					
		Administrator)/DON; but					
	· ·	concern form which was 11. Employee engaged in					
		another employee at					
	nursing station w	1 2					
	_	olinary action being					
	taken:Discharg	e from employment"					
		A CONTRACTOR					
		y Action Report" dated					
	11/18/11 for CN.	A #31 indicated, rule, policy, standard,					
		olation of Abuse Policy.					
		appened- Multiple					
		this employee was					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	A. BUII	LDING	NSTRUCTION 00	` ′	E SURVEY PLETED '2011
NAME OF A	DD OVED ED OD GUIDN IED		B. WIN		DDRESS, CITY, STATE, ZIP C		2011
	PROVIDER OR SUPPLIER				DOUGLAS RD		
		EHABILITATION CENTER		l	VAKA, IN46545		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
	abusive. Investig	gation substantiated					
	_	se. Employee had					
		ation with another staff					
		s station in front of					
		ffDisciplinary action					
	being taken:Di	•					
		/18/11 employee refused					
	,	31) I do NOT AGREE					
	· ·	IAVE NEVER ABUSED					
	ANYONE. (CN	A #31 signature)"					
	2. The clinical re	ecord of Resident #30					
	was reviewed on	12/7/2011 at 12:55 p.m.					
	Resident #30's di	agnoses include, but					
	were not limited	to, HTN (hypertension)					
	and CHF (conge	stive heart failure)					
		ort" dated 11/12/11					
		e first thing I heard this					
		nt #40 telling me she does					
		31 taking care of her, she					
		as rude to her one time.					
		t #30 was leaving the					
		said she had to potty I					
		her girl she slammed me					
	<u>-</u>	air. After second shift					
		resident started saying					
		n the bathroom (Resident					
	`	sic)) and said Resident					
		hings like owe (sic), stop					
		she wished she could get					
	out of that bed ar	na go in there"					
	An unlabeled for	m dated 11/14/11 at					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUILDING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 2/2011	
NAME OF I	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO		
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER		HAWAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETION DATE
	Resident #30- Resident #30- Resident #30- Resident #31 is rougher wheelchair at bathroom before (11/12/11) and the totake her to the She stated she do in trouble but she helping her any resident stated that resident Sunday the toilet and "fleassist another resident Sunday the toilet and "fleassist another resident's room to be doesn't say much she does not want resident's room to employee stated allegation because certification for the been rude or abu Employee further had an argument employee, CNA stated that CNA confrontational at words to her under employee was not to the state of the runder employee was not to the runder employee.	m dated 11/18/11 at 4:00 Employee stated she has ve to a resident. She t she was rushing a (11/13/11) to put her on ew out of the room" to ident who needed yee stated that she to the residents because t to be "stuck" in a alking to themThe she would "fight" this se she has had her 19 years and has not ever				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 26 of 73

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/12/2011		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		1420 E	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
		n; (sic) yet, she knew onfrontation was alleged ce."					
	The "Disciplinar 11/14/11 for CN."Specify work ect., violated- Fa of abuse to DON what happened received concern CNA was abusiv Resident #30. D were notified. O abuser) is on vacemployee is suspinvestigation" The "Disciplinar 11/18/11 for CN."Specify work ect., violated- Vi not reporting per profanity/altercat Described what halleged abuse to to notify HFA (A instead, wrote a creviewed 11/14/1 altercation with a nursing station w	y Action Report" dated A #32 indicated, rule, policy, standard, illure to report allegation //Administrator. Describe On 11/14/11, ADON report alleging another e to Resident #40 and ON and Administrator ne employee (alleged ation thru 11/18/11. This rended pending y Action Report" dated A #32 indicated, rule, policy, standard, olation of Abuse Policy- policy. Use of tion in Resident area. happened- Residents this employee who failed administrator)/DON; but concern form which was 11. Employee engaged in another employee at					
		e from employment"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 27 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
					DOUGLAS RD		
		EHABILITATION CENTER		<u> </u>	NAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		y Action Report" dated	+	TAG			DATE
	11/18/11 for CN	•					
		rule, policy, standard,					
		olation of Abuse Policy.					
	*	appened- Multiple					
		this employee was					
	_	gation substantiated					
	· `	se. Employee had					
	_	ation with another staff					
		s station in front of					
		ffDisciplinary action					
	being taken:Discharge from						
	employment11/18/11 employee refused						
		31) I do NOT AGREE					
	WITH THIS, I F	IAVE NEVER ABUSED					
	ANYONE. (CN	A #31 signature)"					
	Review of a faci	• • •					
		Reporting: Resident					
		eglect, Abuse, Including					
	Injuries of Unkn						
		n of Resident Property",					
		999, revised last July					
	2010, indicated '						
	· ·	HSI) prohibits the					
		glect, and abuse of					
		sappropriation of resident					
		one including staff,					
	<u> </u>	etcEHSI requires					
	_	rt these alleged violations					
		ator and DON/designee					
	_	mmediately" means as					
	_	but ought not to exceed					
	24 nours after di	scovery of incidentThe					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet Page 28 of 73

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2011		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN46545				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	assurance of this oral, written, or gincludes disparage to the resident or their hearing distresidents, regard comprehend or dincludes hitting, scratching, spittietc" During interview Administrator or the Administrator expected to follow	responsible for the policyVerbal abuse is gestured language that ging and derogatory terms their families or within tance, to describe less of their age, ability to disabilityPhysical abuse slapping, pinching, ng, holding roughly, with the facility 12/6/11 at 6:15 P.M., or indicated staff were tow the facility policy and ling reporting and idents involving					
F0282 SS=E	facility must be pro- in accordance with plan of care. Based on intervi- facility failed to and plan of care sliding scale insu	ided or arranged by the ovided by qualified persons in each resident's written ew and record review, the ensure physician orders were followed related to all in for 2 of 6 residents \$\frac{1}{2}\$ 31) reviewed with	F0282	F282It is the practice of this facility that the services prov or arranged by the facility be provided by qualified person accordance with each writter care plan.1. Resident # 31 - notified of the medication err	s in n M.D.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/12/2011		
	PROVIDER OR SUPPLIEI	L R EHABILITATION CENTER	S	1420 E I	DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X COMPL DAT	ETION
	physician orders (Resident # 1, # with parameters the need of a me monitor weights residents (Residents (Residents) (Resident # 46) a sample of 15. ensure physiciar were followed for reviewed for phyplans in a sample of 12/indicated diagnodiabetes mellitus obesity. Review of a "Ph 1/24/11, indicated (insulin)sliding 201-250=4 units 301-350=8 units (greater than) or MD; 7 A.M., 11 P.M"				related to sliding scale discrepancies. No adverse reactions to medication error Resident # 14 - M.D. notified the medication errors related sliding scale discrepancies. adverse reactions to medica errors. ADDENDUM ADDED 1/4/123. Resident # 1 - M.D. notified of error related to administration of Aranesp. Resident is stable. No adverse reaction from medication errors. ADDENDUM Exident # 23 - Resident has discharged from the facility. Resident # 46 - Order for Blook every shift has been discontinued. Resident # 48 Resident is stable. Paramet for medication administration place. Licensed nursing staff in-serviced on proper assessment, monitoring, and documentation related to following physician's orders related to parameters for monitoring medication administration, including but limited to apical pulse, BIOX accu check's, v/s, etc. HOW OTHERS IDENTIFIED: 100 audit of residents with physic orders to assess, monitor, and document parameters relate medication administration, including but not limited to a pulse, BIOX, accu check's, vetc. ADDENDUM ADDED 1/4/12. PREVENTATIVE MEASURES: Residents with physician's orders with parameters for monitoring	of to No ion see or. 4	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155784	A. BUI B. WIN	LDING IG		12/12/2	011
NAME OF I	PROVIDER OR SUPPLIEI	}			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					DOUGLAS RD		
		EHABILITATION CENTER		l .	WAKA, IN46545		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	and 20th through	n 31st, 2011, MAR			medication administration wi		
	(Medication Adı	ministration Record),		have their MAR's monitored to ensure that proper parameters			
	indicated incorre	ect sliding scale coverage			are being followed related to		
	for the following	g seven Accu Checks:			medication adminsitration. A	All	
					finidngs will be recorded on the Clinical Monitoring Tool by U		
		M. Accu Check 239 - 6			Manager's and/or designee		
	units given. Next available Accu Check				will be tracked until follow up		
		M. The clinical record			completed. Any errors or discrepancies will be addres	bas	
	received 4 units.	and fallow up will be me			and follow up will be made to		
	received 4 units.			ensure physician notification and			
	10/3/11 6:00 A.M. Accu Check 232 - 6				proper interventions are in place.ADDENDUM ADDED		
	units given. Next available Accu Check				1/4/12MONITORING: Unit		
	_	M. The clinical record			Managers will monitor Clinic		
	indicated Reside	ent # 31 should have			Monitoring Tool and resident MAR's with parameters daily		
	received 4 units.				weeks, 3 times a week for 8 weeks, weekly for 8 weeks,		
	 10/3/11 11:30 A	.M. Accu Check 350 - 10			monthly for 3 months. All fin		
		kt available Accu Check			will be reviewed at monthly (
	_	The clinical record			meeting.Any deficient praction be addressed through staff	e will	
	indicated Reside	ent # 31 should have			education, in-service, and/or		
	received 8 units.				counseling.		
	10///11 4 00 5	6 A CI 1 251 2					
		M. Accu Check 251 - 2					
		kt available Accu Check The clinical record					
		ent # 31 should have					
	received 6 units.						
	1001, ca o anto.						
	10/24/11 8:00 P.	M. Accu Check 256 - 4					
	units given. Nex	kt available Accu Check					
	186 at 6:00 A.M	. on 10/25/11. The					
		ndicated Resident # 31					
	should have rece	eived 6 units.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETED A. BUILDING A. A			ETED	
		155784	B. WIN	G		12/12/2	011
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD WAKA, IN46545		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG	10/25/11 8:00 P. units given. New 182 at 6:00 A.M clinical record ir should have received 10/30/11 8:00 P. units given. New 333 at 6:00 A.M clinical record ir should have received from the following 11/7/11 6:00 A.M units given. New 250 at 11:30 A.M indicated Reside received 4 units. 11/19/11 11:30 A.M indicated Reside received 4 units. 11/19/11 11:30 A.M indicated Reside received 8 units. 11/24/11 8:00 P.M indicated Reside received 8 units.	M. Accu Check 371 - 6 At available Accu Check . on 10/26/11. The adicated Resident # 31 Eived 10 units. M. Accu Check 359 - 6 At available Accu Check . on 10/31/11. The adicated Resident # 31 Eived 10 units. Ovember, 2011, MAR, Ext sliding scale coverage g three Accu Checks: M. Accu Check 224 - 2 At available Accu Check M. The clinical record ant # 31 should have A.M. Accu Check 310 - 6 At available Accu Check The clinical record ant # 31 should have M. Accu Check 300 - 2 At available Accu Check . on 11/25/11. The adicated Resident # 31		TAG	DEFICIENCY)		DATE

012329

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	·			DOLIGIAS DD	•	
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD WAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	dated 5/11, upda	Diabetes Plan of Care" ted last 11/3/11, minister insulin per MD					
	The clinical record lacked documentation of any medication errors related to incorrect dosage.						
	During interview on 12/9/11 at 10:00 A.M., the ADON (Assistant Director of Nursing) indicated the unit managers are responsible for doing the audits of the sliding scale coverages to identify any errors. She further indicated if the unit managers did identify any errors, the physician notification of those errors would be documented in the nursing notes. Interview with the ADON on 12/9/11 at 11:45 A.M., she indicated the clinical record lacked documentation of sliding scale errors.						
	reviewed on 12/ indicated diagno	ecord for Resident # 14 6/11 at 10:15 A.M., uses of, but not limited to: s, hypertension, and					
		ysician's Order" dated ed, "Novolog (insulin)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	nstruction 00	(X3) DATE : COMPL 12/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	J. 1111	STREET A	DOUGLAS RD		
MICHIAN	NA HEALTH AND R	EHABILITATION CENTER			VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	(bedtime), < 150 176-200=2 units 226-250=4 units 276-300=6 units 326-350=8 units 376-400=10 unit Review of the Orindicated incorre for the following 10/10/11 8:00 P. units given. Nex 334 at 7:00 A.M clinical record in should have rece 10/11/11 7:00 A. units given. Nex 221 at 11:00 A.M indicated Reside received 8 units. 10/24/11 7:00 A. units given. Nex 215 at 11:00 A.M indicated Reside received 5 units. 10/29/11 8:00 P. units given. Nex 212 at 7:00 A.M	a.M. Accu Check 334 - 7 act available Accu Check a.M. The clinical record ant # 14 should have a.M. Accu Check 259 - 3 act available Accu Check a.M. The clinical record ant # 14 should have					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 12/12/2	ETED
NAME OF P	ROVIDER OR SUPPLIER	•			DDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	should have rece	ived 5 units.					
	Review of the Notindicated incorres for the following 11/1/11 8:00 P.M. units given. Nex 204 at 7:00 A.M. record indicated have received 2 to 11/8/11 7:00 A.M. units given. Nex 183 at 11:00 A.M. indicated Reside received 4 units. 11/1/11 4:00 P.M. units given. Nex 201 at 8:00 P.M. indicated Reside received 9 units. Review of the "Edated 9/16, upda indicated,"Adiorder"	ovember 2011, MAR, ct sliding scale coverage athree Accu Checks: M. Accu Check 198 - 1 Lit available Accu Check Lon 11/2/11. The clinical Resident # 14 should units. M. Accu Check 230 - 3 Lit available Accu Check M. The clinical record not # 14 should have M. Accu Check 368 - 8 Lit available Accu Check The clinical record not # 14 should have Diabetes Plan of Care" Led last 12/5/11, minister insulin per MD					
	_						
	During interview	on 12/12/11 at 9:30					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
		100701	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/12/2	
NAME OF F	PROVIDER OR SUPPLIER				DOUGLAS RD		
		EHABILITATION CENTER			VAKA, IN46545		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
		I indicated the facility did		_			
	a 100 % audit of the sliding scale blood						
		as identified during the					
	survey that there	was still an issue with					
	sliding scale erro	rs. She further indicated					
	the facility system	n that was in place was					
		t fully identify the					
	problems.						
	2 The diminal of	and for Decident # 1					
	3. The clinical record for Resident # 1 reviewed on 12/5/11 at 3:00 P.M.,						
	indicated diagnoses of, but not limited to: anemia,hemiplegia, and arthritis.						
	anoma,nompreg	iu, unu uruminis.					
	Review of a "Ph	ysician's Order" dated					
	10/19/11, indicat						
	(medication used	to treat anemia - a low					
	hemoglobin leve	l) 60 mcg					
	(micrograms)/0.3	3 ml (milliliters)inject					
		ection) every week if					
	HGB (hemoglob	in) < 10"					
	Davious of the N	ovember 2011 MAD					
	indicated Reside	ovember 2011, MAR,					
		10.0. The MAR further					
	_	nt # 1 received an					
	Aranesp injection						
	<u>r</u>						
	During interview	with the ADON on					
	12/5/11 at 4:00 F	P.M., she indicated					
	Resident # 1 did	receive an Aranesp					
	injection on 11/2	5/11. She further					
		nt # 1 should not have					
	received the inje-	ction based on the order					

NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER MICHIANA HEALTH AND REHABILITATION CENTER SUMMARY STATIMENT OF DEPELENCES PREERY (EACH DEPCIENCY MUST BE PERCEDED BY FULL TAG Decause her Hemoglobin level was not less than 10.0. 4. The clinical record for Resident # 23, reviewed on 12/5/11 at 4:10 P.M., indicated diagnoses of, but not limited to: atrial fibrillation, hypertension, and congestive heart failure. Review of a Physician Order, dated 11/23/11, indicated, "Digoxin 0.125 mg (milligrams) po (orally) daily8 A.M" Review of the November 23rd through 30th, 2011, Medication Administration Record (MAR) indicated the following three days that lacked apical pulse monitoring: 11/26/11 11/27/11 11/20/11 Review of the December 1st through 5th, 2011, MAR indicated the following three days that lacked apical pulse monitoring: 12/1/11 12/3/11 12/3/11 12/4/11 The clinical record lacked documentation of the apical pulse related to digoxin administration of the apical pulse related to digoxin administration.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
MICHIANA HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (LEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSE DESTIFYING INFORMATION) because her Hemoglobin level was not less than 10.0. 4. The clinical record for Resident # 23, reviewed on 12/5/11 at 4:10 P.M., indicated diagnoses of, but not limited to: atrial fibrillation, hypertension, and congestive heart failure. Review of a Physician Order, dated 11/23/11, indicated, "Digoxin 0.125 mg (milligrams) po (orally) daily8 A.M" Review of the November 23rd through 30th, 2011, Medication Administration Record (MAR) indicated the following three days that lacked apical pulse monitoring: 11/26/11 11/27/11 11/27/11 11/20/11 Review of the December 1st through 5th, 2011, MAR indicated the following three days that lacked apical pulse monitoring: 12/1/11 12/3/11 12/4/11 The clinical record lacked documentation of the apical pulse related to digoxin	NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	_	STREET A			
SUMMARY STATEMENT OF DEFICIENCIES 1D PROPERTY P								
REPETX TAG REGULATORY OR LOS IDENTIFYING INFORMATION) because her Hemoglobin level was not less than 10.0. 4. The clinical record for Resident # 23, reviewed on 12/5/11 at 4:10 P.M., indicated diagnoses of, but not limited to: atrial fibrillation, hypertension, and congestive heart failure. Review of a Physician Order, dated 11/23/11, indicated, "Digoxin 0.125 mg (milligrams) po (orally) daily8 A.M" Review of the November 23rd through 30th, 2011, Medication Administration Record (MAR) indicated the following three days that lacked apical pulse monitoring: 11/26/11 11/27/11 11/30/11 Review of the December 1st through 5th, 2011, MAR indicated the following three days that lacked apical pulse monitoring: 12/1/11 12/3/11 12/3/11 12/3/11 12/3/11 12/3/11 The clinical record lacked documentation of the apical pulse related to digoxin				<u> </u>	l	TANA, INTODES		(V5)
because her Hemoglobin level was not less than 10.0. 4. The clinical record for Resident # 23, reviewed on 12/5/11 at 4:10 P.M., indicated diagnoses of, but not limited to: atrial fibrillation, hypertension, and congestive heart failure. Review of a Physician Order, dated 11/23/11, indicated, "Digoxin 0.125 mg (milligrams) po (orally) daily8 A.M" Review of the November 23rd through 30th, 2011, Medication Administration Record (MAR) indicated the following three days that lacked apical pulse monitoring: 11/26/11 11/27/11 11/30/11 Review of the December 1st through 5th, 2011, MAR indicated the following three days that lacked apical pulse monitoring: 12/1/11 12/3/11 12/4/11 The clinical record lacked documentation of the apical pulse related to digoxin						(EACH CORRECTIVE ACTION SHOULD BE		
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12/3/11 12/4/11 The clinical record lacked documentation of the apical pulse related to digoxin			-F Panet monitoring.					
The clinical record lacked documentation of the apical pulse related to digoxin		12/1/11						
The clinical record lacked documentation of the apical pulse related to digoxin								
of the apical pulse related to digoxin		12/4/11						
of the apical pulse related to digoxin		The clinical reco	ard lacked documentation					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
	PROVIDER OR SUPPLIE	L R EHABILITATION CENTER	p. wiiv	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN46545	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Handbook, indicapical pulse regularite is less than of dose and notify. Review of the 1 "Physician's Ord Weight x (times Weekly Weight 12/7, 12/14, 12/2 Review of a "Weight on 11/30/11 and The clinical record weights on 11/25/11. Review of a "Quality Improvement (Quality Improveme	1/23/11 through 11/30/11 lers" indicated, "Daily) 3, 11/23, 11/24, 11/25; x 4, then monthly, 11/30, 21" eights Detail Report" is for Resident # 23 done 12/6/11. ord lacked documentation 1/23/11, 11/24/11, and hality Performance 2PI) Meeting" form 1/11 at 2:30 P.M., bettingheld on November					

012329

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		ĺ	LDING	NSTRUCTION 00	(X3) DATE S COMPL 12/12/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE	_	
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	was reviewed on Resident #46's di were not limited COPD (Chronic Disease). A "Physician's O through 10/31/11 (oxygen level) ev BIOX PRN & re A "Physician's O through 10/31/11 every shift and re record" A "Physician's O through 11/30/11 every shift and re record" A "Physician's O through 11/30/11 every shift and re record"	12/05/2011 at 3:04 p.m. agnoses include, but to, hypertension and Obstructive Pulmonary order" dated 10/12/11, indicated, "BIOX very shift and record.			CROSS-REFERENCED TO THE APPROPRIA	TE	
	Resident Flowsh through 12/5/11 October From 10/12/11 the was missed on 19 Resident #46 wa	nrough 10/23/11 the biox					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER	•		DDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEAI TH AND R	EHABILITATION CENTER		DOUGLAS RD VAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	•		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		hrough 10/31/11 the biox				
	was missed on 1	υ sniπs. missed completing the				
	biox for October					
	November					
	From 11/1/11 thi	rough 11/2/11 the biox				
	was missed on 2	shifts.				
		s discharged to the				
	_	/2/11 through 11/11/11				
		hrough 11/30/11 the biox				
	was missed on 5	υ sniπs. missed completing the				
	biox for Novemb					
	December)C1 Wd3 32.				
		rough 12/5/11 the biox				
	was missed on 1:	•				
	Total shifts that	missed completing the				
	biox for Decemb	per was 15.				
	A review of the '	"Nursing Notes" dated				
	from 10/13/11 th	arough 12/5/11 indicated				
		rumented on the missing				
	dates as follows:					
		tional shifts not included				
	in the "Vital Sigi Flowsheet."	ns-Individual Resident				
		ditional shifts not				
		Vital Signs-Individual				
	Resident Flowsh	_				
	December: 1 add	litional shift not included				
	in the "Vital Sign	ns-Individual Resident				
	Flowsheet."					
	During and inter	view with the ADON				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 40 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUILDI		OO	(X3) DATE S COMPL 12/12/20	ETED	
		100701	B. WING	TDEET A	DDRESS, CITY, STATE, ZIP CODE	12/12/2	511
NAME OF F	PROVIDER OR SUPPLIER				OOUGLAS RD		
		EHABILITATION CENTER			/AKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	COMPLETION DATE
1710		or of Nursing) 12/5/11 at	-	ino			BATE
	`	licated that the vital signs					
	should be found	•					
		Resident Flowsheet" and					
	~	rsing Notes." She also					
	indicated that if t	•					
		ither of those locations					
	she would assum	e they were not					
	completed.						
	The "Medication	Administration Record"					
	indicated "Hyd	ralazine 50					
	mg(milligram)/ta	abs Give ii (two) tabs =					
	100 mg total dos	e po (by mouth) Q6					
	(every 6 hours) *	Hold for SBP (systolic					
	blood pressure) <	<140 HTN (hypertension)					
		e following dates					
	indicated the SB						
	Hydralazine was						
		blood pressure was					
		ed off as given at 12:00					
	p.m.						
		blood pressure was					
		ed off as given at 12:00					
	p.m.	avatalia bland massauma					
		systolic blood pressure ned off as given at 6:00					
		icu oii as giveii at 0.00					
	p.m. On 10/21/11 the	blood pressure was					
		ed off as given at 12:00					
	p.m.	a on as given at 12.00					
	P.III.						
	6. The clinical re	ecord of Resident #40					
		12/06/2011 at 11:03 a.m.					
				1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 41 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIF A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE (COMPL 12/12/2	ETED	
NAME OF	PROVIDER OR SUPPLIEI	8			ODRESS, CITY, STATE, ZIP CODE		
MICHIA	NA HEALTH AND R	EHABILITATION CENTER			/AKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	were not limited COPD (Chronic	iagnoses include, but to, HTN (hypertension), Obstructive Pulmonary ht sided heart failure.					
	The "SBAR" (Situation/Backg st) form dated 11 indicated, "The calling about if I diagnosis and/or nursing home- S sore), HTN, CO history/include breath)Medica orders in the last (For LPNs): The states has been of (twice a day) + ((daily) for a long (discharged) her (blood pressure) started. Ok to or (Name) MD Dat to MD/NP/PA, oby:Fax" An unlabeled for 11/9/11 sent to I Resident #40 incomplete III states B/P has be was D/C. It was	ground/Assessment/Reque 1/1/11 at 3:00 p.m. e problem/symptom I am HTN, new admitPrimary reason resident is at the tage III decub (pressure PD. Pertinent medical .SOB (shortness of tion changes of new two weeks- New admit e patient appears- upset on Atenolol 100 mg BID and) Quinapril 20 mg QD g time. Hospital D/C to us w/o (without) BP meds. Wants these rder?Reported to: Dr. e: 11/1/11 Time: 3 pm. If					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND FLAIN	OI CORRECTION	155784	ι.	A. BUILI		00		12/12/2	
		100704		B. WING				12/12/2	V 1 1
NAME OF F	ROVIDER OR SUPPLIER	t				ADDRESS, CITY, STA	ATE, ZIP CODE		
MICHIAN		EHABILITATION CEN	TED			DOUGLAS RD NAKA, IN46545	:		
				1		WANA, IIN40040	,		
(X4) ID		TATEMENT OF DEFICIENCE			ID		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY		Р	REFIX TAG	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION DATE
TAG		LSC IDENTIFYING INFORM	IATION)		IAG	DLI	Tellave 1)		DATE
	25 mg/day"								
	_	-Individual Resident							
		0/31/11 through 12/5							
		lowing blood pressure							
		:30 p.m. a blood pres	ssure						
	of 169/63.								
		00 a.m. a blood press	ure						
	of 180/67.								
		00 a.m. a blood press	ure						
	of 163/67.								
	On 11/7/11 at 8:0	00 a.m. a blood press	ure						
	of 177/84.								
	On 11/8/11 at 8:0	00 a.m. a blood press	ure						
	of 184/94.								
	On 11/9/11 at 8:0	00 a.m. a blood press	ure						
	of 162/86.	•							
	A "Physician Or	der" dated 11/09/11							
	1	enolol 25 mg tablet	Give						
	1 tablet orally on	•							
	i taoiet orang on	ice a aay							
	A "Physician Or	der" dated 12/02/11							
		d Atenolol is SBP							
	<110"	d Micholol 13 BB1							
	`11U								
	The "Vital Signs	-Individual Resident							
	_	d 12/2/11 indicated th							
	blood pressure w								
		ministration Record"							
		dicated the Atenolol	was						
	given.								
	m urri tor								
	The "Vital Signs	-Individual Resident							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete E	vent ID: SB	34V11	Facility I	D: 012329	If continuation sh	neet Pa	ge 43 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 12/12/2	ETED
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		1420 E D	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0309 SS=D	Flowsheet" dated blood pressure w "Medication Adridated 12/3/11 incigiven. 3.1-35(g)(2) Each resident must must provide their to attain or maintal physical, mental, a in accordance with assessment and p Based on intervier facility failed to pain medication in pain for 1 of 9 rein a sample of 15. Findings include	at receive and the facility licated the Atenolol was set receive and the facility licated the Atenolol was set receive and services in the highest practicable and psychosocial well-being, a the comprehensive lan of care. It was and record review, the provide the necessary to control a resident's sidents reviewed for pain at a control of the control	F03		F309It is the practice of this facility that each resident recand the facility provides the necessary care and services attain or maintain the highest practicable physical, mental, psychosocial well-being, comprehensive assessment plan of care.CORRECTIVE ACTION: Resident # 40 -	eives to t and and	DATE 01/09/2012
	reviewed on 12/0 Resident #40's di were not limited COPD (Chronic Disease), right si	rd of Resident #40 was 16/2011 at 11:03 a.m. agnoses include, but to, HTN (hypertension), Obstructive Pulmonary ded heart failure, infected tageable pressure sores, nd chronic Cor			Resident has current order for routine and prn pain medication. Written notice set to physician/Medical Director regarding responsibilities for management of residents. In event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact	nt pain the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 44 of 73

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		LDING	nstruction 00	(X3) DATE (COMPL 12/12/2	ETED
	NAME OF PROVIDER OR SUPPLIER MICHIANA HEALTH AND REHABILITATION CENTER			1420 E I	DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated, "Hydrake 2 PO (by m for pain PRN (as The "Medication dated 11/1/11 the Resident #40 req hydrocodone-AF times out of an a A "Physician's O indicated, "Hydrag IC: Norco 5-tablets orally ever pain" The "Medication dated 11/11/11 the indicated Reside hydrocodone-AF times out of an a A "Physician's O indicated a change to a scheduled rousHydrocodone q6 (every 6 hour On the back of the Administration FPRN Notes" date "Norco 5-325 of the indicated a change to a scheduled rousHydrocodone q6 (every 6 hour on the back of the Administration FPRN Notes" date "Norco 5-325 of the indicated a change to a scheduled rousHydrocodone q6 (every 6 hour on the back of the Administration FPRN Notes" date "Norco 5-325 of the indicated a change to a scheduled rousNorco 5-325 of the indicated a change to a scheduled rous	Administration Record" rough 11/10/11 indicated quested the PAP PRN medication 22 vailable 40 doses. Orders" dated 11/11/11 drocodone APAP 5-325 325 TabletGive 2 ery 6 hours as needed for Administration Record" nrough 11/24/11 nt #40 requested the PAP PRN medication 35 vailable 56 doses. Orders" dated 11/22/11 ge from PRN (as needed) outine order, 5/325 2 po (by mouth) s)"			physician/Medical Director. event Adminstrator and/or D. are unable to get resolution to resident will be sent to the E. for evaluation and treatment. HOW OTHERS IDENTIFIED: Residents resi in the facilty will be addressed notification sent to physician/Medical Director. PREVENTATIVE MEASURES: A.D.O.N. and/designee will review promedication logs on Thursday each week to check the curre availability and the amount of medication on hand against to possible need and will obtain order from physician on Frida during rounds to prevent exhausting supply on weekends. MONITORING: A.D.O.N. and/or designee will monitor the pain medication to ensure medication is avail Medication logs will be monit daily for 2 weeks, 3 times a word for 8 weeks, weekly for 8 week and monthly for 3 months. A findings will be reviewed at monthly QPI meeting. Any deficient practice will be addressed through staff education, in-service, and/or counseling.	O.N. he R. ding d by or of ent f the lays able. ored veek eks,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784				LDING	NSTRUCTION 00	(X3) DATE COMPL 12/12/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•	
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			DOUGLAS RD NAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710	for Dr. (Name)		+	mo	<u> </u>		DATE
	On the back of the						
		Record" in the "Nurses					
		ed 11/30/11 at 12 a.m.					
	"Vicodin not a	vailable"					
	The "Medication	Administration Record"					
		ndicated the next dose of					
	Hydrocodone Al	PAP 5-325 was given at					
	12:00 p.m.						
	A UNI maiore Nice	W 4-4-4 11/20/11 -4 6-00					
		e" dated 11/29/11 at 6:00					
		No Norco in stock for (Pharmacy Name). They					
		I two papers to Dr.					
		to get a signed order but					
	no response from						
	1						
		e" dated 11/29/11 at 7:00					
	1 *	Phoned Dr. (Name) asked					
		for Norco he stated "no					
		g it tonight" I stated					
		npletely out of pain meds.					
	He said it will will will informed residen	ait until morning. I then					
	miorined residen	IL.					
	During an interv	iew on 12/5/11 at 5:00					
		Manager #28 she indicated					
	that according to	the "Medication					
	Administration F	Record," Resident #40					
	was out of her pa	ain medication,					
	Hydrocodone Al	PAP 5-325, from					
	11/29/11 at 12:00	0 p.m. until 11/30/11 at					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted /2011
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET 1420 E	ADDRESS, CITY, STATE, ZIP EDOUGLAS RD WAKA, IN46545	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	During an interval 12/6/11 at 4:35 p was concerned at refills from her p facility. She indiffers time she has refill on a medical specifically remember her pain must that she did take medication, Tyle better pain control. She included to Social Services	iew with Resident #40 on a.m. she indicated that she bout getting medication shysician while in the licated that this is not the shad to wait over 24 for a lation at this facility. She embers this time due to it edication. She indicated her PRN (as needed) nol, but felt that she has ol when she had her lided that she is upset due is telling her that her liver physician were not				

012329

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/12/2011	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD	
MICHIAN	A HEALTH AND RE	EHABILITATION CENTER		WAKA, IN46545	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
F0329 SS=D	from unnecessary drug is any drug w (including duplicat duration; or without without adequate in the presence of accordinate the dose of discontinued; or an reasons above. Based on a comproposition of the facility residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsumented in the residents who have dose the facility failed to do furnecessary monitor vital sign reviewed with parevaluate the needs sample of 15. [Resident # 23, # Findings include 1. The clinical reviewed on 12/5 indicated diagnost atrial fibrillation, atrial fibrillation, atrial fibrillation, atrial fibrillation, atrial fibrillation.	ecord for Resident # 23, 5/11 at 4:10 P.M., ses of, but not limited to: hypertension, and	F0329	F329It is the practice of this facility that each residents dr regimen is free from unneces drugs.CORRECTIVE ACTIO 1. Resident # 23 - Resident # been discharged from facility.ADDENDUM ADDED 1/4/122. Resident # 46 - M.I. notified related to obtain BIO every shift. Resident is stabl Order for BIOX every shift habeen discontinued.Licensed nursing staff in-serviced on proper assessment, monitori and documentation related to following physician's orders related to parameters for monitoring medication administration, including but	ssary N: nas D. X le. as
	congestive heart			administration, including but limited to apical pulse, BIOX,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329 If continuation sheet

Page 48 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155784	B. WIN			12/12/20	011
NAME OF B	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		1420 E	DOUGLAS RD		
		EHABILITATION CENTER			WAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)		TAG	,		DATE
TAG	Review of a Phy 11/23/11, indicate (milligrams) pool Review of the N 30th, 2011, Med Record (MAR) is three days that la monitoring: 11/26/11 11/27/11 11/30/11 Review of the D 2011, MAR indicated days that lacked 12/1/11 12/3/11 12/4/11 The clinical record of the apical pulsadministration. Review of a "Care" da"Meds/Tx (treated)	rsician Order, dated ted, "Digoxin 0.125 mg (orally) daily8 A.M" ovember 23rd through ication Administration indicated the following acked apical pulse ecember 1st through 5th, cated the following three apical pulse monitoring: ord lacked documentation se related to digoxin rdiovascular/Circulatory: ted 11/24/11, indicated, atment) as or for sign/symptoms of		TAG	accu check's, v/s, etc.HOW OTHERS IDENTIFIED: 100 audit of residents with physic orders to assess, monitor, ar document parameters relate medication administration, including but not limited to ap pulse, BIOX, accu check's, v etc.ADDENDUM ADDED 1/4/12PREVENTATIVE MEASURES: Residents with parameters for monitoring medication administration wi have their MAR's monitored ensure that proper paramete are being followed related to medication administration. Findings will recorded on Clinical Monitori Tool and tracked until follow completed by Unit Manager. errors or discrepancies will be addressed and follow up will made to ensure physician notification and proper interventions are in place.ADDENDUM ADDED 1/4/12MONITORING: Unit Managers will monitor Clinic Monitoring Tool and the resid MAR's with parameters daily weeks, 3 times a week for 8 weeks, weekly for 8 weeks, a monthly for 3 months. Findin will be reivewed at monthly 0 meeting.Any deficient practic be addressed through staff	cian's and do to pical r/s, he ll to sers the being up is Any se be all dents r for 2 and angs QPI	DATE
	cardiac distress				education, in-service, and/or		
	cardiac distress				counseling.		
	During interview	w with the ADON on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		LDING	NSTRUCTION 00	(X3) DATE (COMPL 12/12/2	ETED	
NAME OF P	PROVIDER OR SUPPLIER	· !		DDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER		DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	apical pulse wou	A.M., she indicated the ald either be documented the vital sign sheet.				
	Handbook, indicapical pulse regurate is less than 6 dose and notify proceeding to the control of	der" dated 11/09/11 enolol 25 mg tabletGive ace a day" der" dated 12/02/11 d Atenolol is SBP				
	_	-Individual Resident d 12/3/11 indicated the vas 105/66. The				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 50 of 73

	OF CORRECTION OF CORRECTION 155784 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/12/2011
	PROVIDER OR SUPPLIER NA HEALTH AND REHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD NAKA, IN46545	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	"Medication Administration Record" dated 12/3/11 indicated the Atenolol was given. 3.1-48(a)(6)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure 3 of 15 residents reviewed with medication orders were free of significant medication orders in a sample of 15. [Residents # 1, # 14, # 31] Findings include: 1. The clinical record for Resident # 31 reviewed on 12/8/11 at 10:50 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and obesity. Review of a "Physician's Order" dated 1/24/11, indicated, "Novolin R (insulin)sliding scale; 150-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; > (greater than) or < (less than) 60=call MD; 7 A.M., 11:30 A.M., 4 P.M., 9 P.M"	F0333	F333It is the practice of this facility that residents are free significant medication errors.CORRECTIVE ACTION:ADDENDUM ADDE 1/4/121. Resident # 1 - M.D notified of error related to administration of Aranesp. Resident is stable. No advereaction from medication errors related to sliding scale discrepancies. adverse reaction to medicati errors.3. Resident # 31 - M notified of medication errors related to sliding scale discrepancies. adverse reaction to medicati errors.3. Resident # 31 - M notified of medication errors related to sliding scale discrepancies. No adverse reaction to medication errors Licensed nursing staff in-ser on proper assessment, monitoring, and documentati related to following physiciar orders related to parameters monitoring medication administration, including but limited to apical pulse, BIOX accu check's, v/s, etc.HOW OTHERS IDENTIFIED: 100	rse or.2. I of No on .D. S. viced ion n's i for not

012329

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE COMPL	
		155784	A. BUI B. WIN	LDING IG		12/12/2	011
		EHABILITATION CENTER TATEMENT OF DEFICIENCIES	1	1420 E	DDDRESS, CITY, STATE, ZIP CODE DOUGLAS RD NAKA, IN46545		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
	and 20th through (Medication Adrindicated incorre for the following 10/3/11 6:00 A.M. units given. Nex 350 at 11:30 A.M. indicated Reside received 4 units. 10/3/11 11:30 A. units given. Nex 305 at 4:00 P.M. indicated Reside received 8 units. 10/6/11 4:00 P.M. units given. Nex 395 at 9:00 P.M. indicated Reside received 6 units. 10/24/11 8:00 P.M. indicated Reside received 6 units. 10/24/11 8:00 P. units given. Nex 186 at 6:00 A.M. clinical record in should have received 10/25/11 8:00 P. units given. Nex 10/25/11 8:00 P. units given.	ctober 1st through 17th a 31st, 2011, MAR ministration Record), ct sliding scale coverage seven Accu Checks: M. Accu Check 232 - 6 ct available Accu Check M. The clinical record mt # 31 should have M. Accu Check 350 - 10 ct available Accu Check The clinical record mt # 31 should have M. Accu Check 251 - 2 ct available Accu Check The clinical record mt # 31 should have M. Accu Check 251 - 2 ct available Accu Check The clinical record mt # 31 should have M. Accu Check 256 - 4 ct available Accu Check On 10/25/11. The dicated Resident # 31 ived 6 units. M. Accu Check 371 - 6 ct available Accu Check On 10/26/11. The			audit of residents with physicorders to assess, monitor, ar document parameters related medication administration, including but not limited to appulse, BIOX, accu check's, vetc.PREVENTATIVE MEASURES: Residents with physician's orders with parameters for monitoring medication administration will have their MAR's monitored ensure that proper paramete are being followed related to medication administration. Findings will be recorded on Clinical Monitori Tool and tracked until follow completed. Any errors or discrepancies will be address and follow up will be made to ensure physician notification proper interventions are in place.ADDENDUM ADDED 1/4/12MONITORING: Unit Managers will monitor the Cli Monitoring Toola and resider MAR's with parameters daily weeks, 3 times a week for 8 weeks, weekly for 8 weeks, a monthly for 3 months. Findin will be reivewed at monthly 0 meeting.Any deficient practic be addressed through staff education, in-service, and/or counseling.	ind did to bical /s, in litto rs the pe ng up is sed of and inical ints for 2 and ings QPI is will	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/12/2	LETED	
NAME OF I	PROVIDER OR SUPPLIEI	R	•		DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER			VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	clinical record in should have rece	ndicated Resident # 31 eived 10 units.					
	units given. Nex 333 at 6:00 A.M	M. Accu Check 359 - 6 kt available Accu Check on 10/31/11. The indicated Resident # 31 eived 10 units.					
	Review of the November, 2011, MAR, indicated incorrect sliding scale coverage for the following three Accu Checks:						
	11/7/11 6:00 A.M. Accu Check 224 - 2 units given. Next available Accu Check 250 at 11:30 A.M. The clinical record indicated Resident # 31 should have received 4 units.						
	units given. Nex 348 at 4:00 P.M	A.M. Accu Check 310 - 6 ext available Accu Check The clinical record ent # 31 should have					
	units given. Nex 300 at 6:00 A.M	M. Accu Check 300 - 2 kt available Accu Check on 11/25/11. The ndicated Resident # 31 eived 6 units.					
	dated 5/11, upda	Diabetes Plan of Care" ated last 11/3/11, minister insulin per MD					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/12/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET A 1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD WAKA, IN46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A.M., the ADON Nursing) indicate responsible for d sliding scale coverrors. She furth managers did ide physician notific would be documentes. 2. The clinical reviewed on 12/6 indicated diagnor diabetes mellitus hyperlipidemia. Review of a "Phy 9/15/11, indicate sliding scaleAC (bedtime), < 150 176-200=2 units; 226-250=4 units; 276-300=6 units; 326-350=8 units; 376-400=10 unit. Review of the Odindicated incorrefor the following	I (Assistant Director of ed the unit managers are oing the audits of the erages to identify any er indicated if the unit entify any errors, the ation of those errors ented in the nursing ecord for Resident # 14 5/11 at 10:15 A.M., ses of, but not limited to: , hypertension, and visician's Order" dated d, "Novolog (insulin) C (before meals) & HS =0 units; 151-175=1 unit; 201-225=3 units; 251-275=5 units; 301-325=7 units; 351-375=9 units; s; > 400=call doctor" etober 2011, MAR, ct sliding scale coverage four Accu Checks: M. Accu Check 208 - 2			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 54 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155784	B. WIN			12/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				DOLIGI AS DD		
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER			DOUGLAS RD NAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		t available Accu Check					21111
	"	on 10/11/11. The					
	clinical record in	dicated Resident # 14					
	should have rece	ived 3 units.					
		M. Accu Check 334 - 7					
	~	t available Accu Check					
		I. The clinical record nt # 14 should have					
	received 8 units.						
	received 8 units.						
	10/24/11 7:00 A.M. Accu Check 259 - 3						
		t available Accu Check					
	_	 The clinical record 					
	indicated Residen	nt # 14 should have					
	received 5 units.						
	10/20/11 0 00 0	N. A. Cl. 1 252 2					
		M. Accu Check 252 - 3					
	_	t available Accu Check on 10/30/11. The					
		dicated Resident # 14					
	should have rece						
	Review of the No	ovember 2011, MAR,					
		ct sliding scale coverage					
	for the following	three Accu Checks:					
	11/1/11 Q:00 D N	I. Accu Check 198 - 1					
		t available Accu Check					
	~	on 11/2/11. The clinical					
		Resident # 14 should					
	have received 2 i						
	11/8/11 7:00 A.N	M. Accu Check 230 - 3					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIP A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE : COMPL 12/12/2	ETED	
NAME	OF PROVIDER OR SUPPLIER	<u> </u>	STR	DDRESS, CITY, STATE, ZIP CODE		
MICH	IANA HEALTH AND R	EHABILITATION CENTER		DOUGLAS RD VAKA, IN46545		
(X4) II PREFI TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	183 at 11:00 A.N indicated Reside	units given. Next available Accu Check 183 at 11:00 A.M. The clinical record indicated Resident # 14 should have received 4 units.				
	units given. Nex 201 at 8:00 P.M.	M. Accu Check 368 - 8 At available Accu Check The clinical record Int # 14 should have				
	dated 9/16, upda	Diabetes Plan of Care" ted last 12/5/11, minister insulin per MD				
	A.M., the ADON a 100 % audit of sugars when it w survey that there sliding scale erro the facility syste	on 12/12/11 at 9:30 N indicated the facility did I the sliding scale blood was identified during the was still an issue with ors. She further indicated on that was in place was It fully identify the				
	reviewed on 12/2 indicated diagno anemia, hemiples Review of a "Ph 10/19/11, indica	ysician's Order" dated				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULT A. BUILDII B. WING		OO	(X3) DATE S COMPLI 12/12/20	ETED	
NAME OF P	ROVIDER OR SUPPLIER				DOUGLAS RD		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER			'AKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	·	3 ml (milliliters)inject ection) every week if					
	indicated Resider Hemoglobin was	10.0. The MAR further nt # 1 received an					
	12/5/11 at 4:00 P Resident # 1 did injection on 11/2 indicated Residen received the injection	with the ADON on P.M., she indicated receive an Aranesp 5/11. She further int # 1 should not have ection based on the order and application of the order and application of the order					
	3.1-25(b)(9)						
F0371 SS=F	considered satisfa local authorities; a	, distribute and serve food					
	facility failed to opreparation areas	ation and interview, the ensure the food were clean and sanitary k of proper utilization of	F037	1	F371It is the practice of this facility to store, prepare, distrand serve food under sanitar conditions.CORRECTIVE ACTION: Staff in-serviced or proper use of hairnets and be	y n	01/09/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 57 of 73

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		LDING	nstruction 00	(X3) DATE COMPL 12/12/2	ETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	F	1420 E	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	while serving me practice had the 73 residents who in 1 of 1 facility Findings include On 12/5/11 at 5:: employees (Regident of the Property	20 p.m. a total of 8 stered Dietician #21, 2, Dietary Aide #23, #25, Unit Manager #28, er #29) were observed then and leaving the that does not require hair loyees were observed of the serving area and the serving area			protectors while in kitchen area.HOW OTHERS IDENTIFIED: Residents resi in the facility will be addresse in-servicing staff on proper u hairnets and beard protectors.PREVENTATIVE MEASURES: Staff entering kitchen will be monitored for proper use of hairnets and be protectors through observation ADDENDUM ADDED 1/4/12MONITORING: All 3 rt to be monitored by CDM and desginee daily for 2 weeks, 3 times a week for 8 weeks, we for 8 weeks, and monthly for months. Findings will be reviewed at monthy QPI meeting.Any deficient practic be addressed through staff education, in-service, and/or counseling.	ed by se of the eard on. meals l/or 3 eekly 3	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 58 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155784	B. WING		12/12/2011
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD	
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER	MISHA	WAKA, IN46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F0385	should have had further indicated them put them or 3.1-21(i)(1)	personally approve in writing			
SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on interview and record review, the facility failed to ensure a resident's medical care was supervised by a physician related to pain medication for 1 of 9 residents reviewed for pain in a sample of 15. [Resident #40] Findings include: The clinical record of Resident #40 was reviewed on 12/06/2011 at 11:03 a.m. Resident #40's diagnoses include, but were not limited to, HTN (hypertension), COPD (Chronic Obstructive Pulmonary Disease), right sided heart failure, infected Stage III and unstageable pressure sores,		F0385	F385It is the practice of this facility that the medical care each resident is supervised by physician; and another physician; and another physician supervises medical care of residents when their attending physician is unavailable. CORRECTIVE ACTION: Resident # 40 - Resident has current order for routine and prn pain medication. Written notice set to physician/Medical Director regarding responsibilities for management of residents. In event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator	oy a cian g or nt pain n the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 59 of 73

		(X2) M			ľ í	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	
		155784	B. WIN	G		12/12/2	011
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
MICHIAN		EHABILITATION CENTER			DOUGLAS RD WAKA, IN46545		
					WAKA, IN40040		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	Pulmonale.	CESC IDENTIF TING INFORMATION)		IAG	and/or D.O.N. will contact		DATE
	runnonaie.				physician/Medical Director.	In the	
	A UDL sisisula C	N. J			event Adminstrator and/or D		
	A "Physician's Orders" dated 10/31/11 indicated, "Hydrocodone-APAP 5-325				are unable to get resolution		
					resident will be sent to the E for evaluation and	R.	
	` •	nouth) Q6 (every 6 hours)			treatment.HOW OTHERS		
	for pain PRN (as	s needed)			IDENTIFIED: Residents res		
	The "Madiestics	A durinistration Describ			in the facilty will be address	ed by	
		n Administration Record"			notification sent to physician/Medical		
		rough 11/10/11 indicated			Director.PREVENTATIVE		
	Resident #46 requested the				MEASURES: A.D.O.N. and	/or	
	hydrocodone-APAP PRN medication 22 times out of an available 40 doses.				designee will review prn		
	times out of an a	ivaliable 40 doses.			medication logs on Thursda each week to check the curr		
	A UDbassisiants C	Nudanali daka d 11/11/11			availability and the amount		
	<u>-</u>	Orders" dated 11/11/11			medication on hand against		
	_	drocodone APAP 5-325		possible need and will obtain			
	•	-325 TabletGive 2			order from physician on Frid	ays	
	1	ery 6 hours as needed for			during rounds to prevent exhausting supply on		
	pain"				weekends.MONITORING:		
	TEL . UNA . 1:	. A 1			A.D.O.N. and/or designee w		
		n Administration Record"			monitor the pain medication		
	dated 11/11/11 t	•			to ensure medication is avail Medication logs will be mon		
		ent #46 requested the			daily for 2 weeks, 3 times a		
	1 -	PAP PRN medication 35			for 8 weeks, weekly for 8 we		
	times out of an a	available 56 doses.			and monthly for 3 months.	All	
	A !!Dlavaiaiaa!	Andonall data d 11/20/11			findings will be reviewed at monthly QPI meeting.Any		
	1	Orders" dated 11/22/11			deficient practice will be		
		ge from PRN (as needed)			addressed through staff		
	to a scheduled ro				education, in-service, and/o	٢	
	1	2 5/325 2 po (by mouth)			counseling.		
	q6 (every 6 hour	S)					
	On the back of t	ha "Madigation					
		Record" in the "Nurses					
	rkin inotes" dat	ed 11/29/11 at 6 p.m.					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 2/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STRE 1420	ET ADDRESS, CITY, STATE, ZIP DE DOUGLAS RD HAWAKA, IN46545	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		out of stock and no order e to no faxed signature ."				
		Record" in the "Nurses and 11/30/11 at 12 a.m.				
	dated 11/30/11 in	Administration Record" adicated the next dose of PAP 5-325 was given at				
	p.m. indicated, "I resident. Called stated they faxed	" dated 11/29/11 at 6:00 No Norco in stock for (Pharmacy Name). They two papers to Dr. o get a signed order but him."				
	p.m. indicated, "I him for an order he was not doing resident was com	" dated 11/29/11 at 7:00 Phoned Dr. (Name) asked for Norco he stated "no it tonight" I stated apletely out of pain meds. ait until morning. I then t."				
	p.m. with Unit M that according to	Record," Resident #46				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULT A. BUILDI B. WING		OO	(X3) DATE S COMPLI 12/12/20	ETED	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	1	1420 E D	DDRESS, CITY, STATE, ZIP CODE OUGLAS RD AKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
		PAP 5-325, from Op.m. until 11/30/11 at proximately 30 hours.					
	12/6/11 at 4:35 p was concerned al refills from her p facility. She indi- first time she has refill on a medica specifically reme- being her pain m that she did take medication, Tyle better pain contro Norco. She inclu- to Social Service	ew with Resident #46 on .m. she indicated that she bout getting medication hysician while in the cated that this is not the had to wait over 24 for a ation at this facility. She embers this time due to it edication. She indicated her PRN (as needed) nol, but felt that she has ol when she had her aded that she is upset due is telling her that her er physician were not					
	3.1-22(a)(1) 3.1-22(a)(2)						
F0389 SS=D	provision of physic day, in case of an Based on intervie facility failed to physician service hours per day for	ew and record review, the ensure emergency es were available 24 of 15 residents per medical care in a	F038	39	F389It is the practice of this facility to provide or arrange of the provision of Physicain Services 24 hours a day, in cof emergency. CORRECTIV ACTION: Resident # 40 - Resident has current order for routine and prn pain medication. Written notice ser	ase E or	01/09/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SB4V11 Facility ID: 012329

If continuation sheet

Page 62 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			ULTIPLE COI LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/12/2	ETED	
		1557 64	B. WIN			12/12/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER		MISHAV	VAKA, IN46545		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	TE	COMPLETION	
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	,		DATE
TAG	Findings include The clinical recoreviewed on 12/0 Resident #40's diwere not limited COPD (Chronic Disease), right si Stage III and unstrhadomyolysis, a Pulmonale. A "Physician's O indicated, "Hyo Take 2 PO (by m for pain PRN (as The "Medication dated 11/1/11 thr Resident #40 req hydrocodone-AP times out of an ar A "Physician's O indicated, "Hyo mg IC: Norco 5-6 tablets orally ever pain" The "Medication dated 11/1/11 the indicated Resident indicated Resident indicated Resident indicated Resident indicated Resident indicated Resident indicated indicated Resident indicated Resident indicated indicated indicated Resident indicated Resident indicated indicated indicated Resident indicated indicated Resident indicated indicated indicated indicated indicated Resident indicated ind	rd of Resident #40 was 16/2011 at 11:03 a.m. agnoses include, but to, HTN (hypertension), Obstructive Pulmonary ded heart failure, infected tageable pressure sores, and chronic Cor rders" dated 10/31/11 drocodone-APAP 5-325 touth) Q6 (every 6 hours) needed)" Administration Record" rough 11/10/11 indicated uested the PAP RN medication 22 vailable 40 doses. rders" dated 11/11/11 drocodone APAP 5-325 325 TabletGive 2 ary 6 hours as needed for		TAG	to physician/Medical Director regarding responsibilities for management of residents. In event the nursing staff get ar inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact physician/Medical Director. I event Administrator and/or D. are unable to get resolution to resident will be sent to the E. for evaluation and treatment. HOW OTHERS IDENTIFIED: Residents resign the facility will be addressed notification sent to physician/Medical Director. PREVENTATIVE MEASURES: A.D.O.N. and/designee will review promedication logs on Thursday each week to check the curred availability and the amount of medication on hand against the possible need and will obtain order from physician on Friday during rounds to prevent exhausting supply on weekends. MONITORING: A.D.O.N. and/or designee will monitor the pain medication is available for 2 weeks, 3 times a very for 8 weeks, weekly for 8 weeks and monthly for 3 months. A findings will be reviewed at	pain in the interest in the i	DATE
	•	vailable 56 doses.			monthly QPI meeting.Any deficient practice will be		
	unies out of all a	valiable 30 doses.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11 Facility ID:

012329

If continuation sheet

Page 63 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		LDING	NSTRUCTION 00	(X3) DATE COMPI 12/12/2	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1420 E I	DDRESS, CITY, STATE, ZIP CODE DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated a change to a scheduled rouse of the school of the school of the Administration of the PRN Notes date "Norco 5-325 of to get in EDK due for Dr. (Name) On the back of the Administration of the present of the Administration of the PRN Notes date "Vicodin not a "	5/325 2 po (by mouth) s)" ne "Medication Record" in the "Nurses ed 11/29/11 at 6 p.m. out of stock and no order ne to no faxed signature ." ne "Medication Record" in the "Nurses ed 11/30/11 at 12 a.m. vailable" Administration Record" ndicated the next dose of PAP 5-325 was given at "dated 11/29/11 at 6:00 No Norco in stock for (Pharmacy Name). They two papers to Dr. o get a signed order but		addressed through staff education, in-service, and/o counseling.	r	

		[X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				NSTRUCTION 00		(X3) DATE COMPL	
12.12112111		155784		. BUILD	ING			12/12/2	
			В	B. WING	CTDEET 4	DDRESS, CITY, STAT	TE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER					DOUGLAS RD	E, ZIF CODE		
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER				VAKA, IN46545			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLA	AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PI	REFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		IENCY)		DATE
	he was not doing	git tonight" I stated							
	resident was com	pletely out of pain meds.							
	He said it will wa	ait until morning. I then							
	informed residen	t."							
	During and inter	view on 12/5/11 at 5:00							
	_	Sanager #28 she indicated							
	that according to	•							
	_	Record," Resident #40							
	was out of her pa								
	Hydrocodone AF	-							
		0 p.m. until 11/30/11 at							
		proximately 30 hours.							
	0.00 p.m. for app	noamatery 50 hours.							
	During an intervi	iew with Resident #40 on							
	12/6/11 at 4:35 p	o.m. she indicated that she							
	was concerned al	bout getting medication							
		physician while in the							
	-	icated that this is not the							
	1	s had to wait over 24 for a							
		ation at this facility. She							
		embers this time due to it							
		edication. She indicated							
		her PRN (as needed)							
		enol, but felt that she has							
		ol when she had her							
	•	aded that she is upset due							
		es telling her that her							
		ner physician were not							
	reasonable.	ioi pirysioiani word not							
	reasonaute.								
	3.1-22(e)								
	3.1 22(0)								
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	SB4	V11	Facility I	D: 012329	If continuation sh	neet Pa	ge 65 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/12/2011		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS RD NAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0490 SS=D	that enables it to use and efficiently to a practicable physic well-being of each Based on intervise facility failed to guaranteed unint 1 of 15 residents medical care in a # 40] Findings include The clinical recorreviewed on 12/0 Resident #40's diwere not limited COPD (Chronic Disease), right si Stage III and unstrhadomyolysis, a Pulmonale. A "Physician's O indicated, "Hyo Take 2 PO (by more for pain PRN (as The "Medication dated 11/1/11 thr Resident #40 req hydrocodone-AP	ew and record review, the ensure the Administrator errupted medical care for reviewed for proper sample of 15. [Resident and of Resident #40 was 16/2011 at 11:03 a.m. agnoses include, but to, HTN (hypertension), Obstructive Pulmonary ded heart failure, infected tageable pressure sores, and chronic Cor arders" dated 10/31/11 alrocodone-APAP 5-325 touth) Q6 (every 6 hours) needed)" Administration Record" ough 11/10/11 indicated	FO	0490	F490It is the practice of this facility to use its resources effectively and efficiently to a or maintain the highest practicable physical, mental, psychosocial well-being of eresident. CORRECTIVE ACT Resident # 40 - Resident has current order for routine and pain medication. Written notic sent to physician/Medical Diregarding responsibilities for management of residents. In event the nursing staff get an inappropriate response from physician related to resident orders the nurse is to call Administrator and/or D.O.N. immediately. Administrator and/or D.O.N. will contact physician/Medical Director. event Adminstrator and/or D are unable to get resolution to resident will be sent to the E for evaluation and treatment. HOW OTHERS IDENTIFIED: Residents resin the facility will be addressed notification sent to physician/Medical Director. PREVENTATIVE MEASURES: A.D.O.N. and/designee will review prn medication logs on Thursday each week to check the curred availability and the amount of the second service of the second servic	and ach ION: s prn ce rector pain in the In the IO.N. he IR. diding did by	01/09/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784			LDING	NSTRUCTION 00	` ′	E SURVEY LETED 2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	P . Will	1420 E	DOUGLAS RD NAKA, IN46545	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	indicated, "Hydrog IC: Norco 5-tablets orally ever pain" The "Medication dated 11/11/11 the indicated Reside hydrocodone-AFtimes out of an an an A "Physician's Condicated a change to a scheduled row "Hydrocodone q6 (every 6 hour on the back of the Administration For PRN Notes" date "Norco 5-325 of to get in EDK due for Dr. (Name) On the back of the Administration For PRN Notes of the Administration For Notes of the Administration For PRN Notes of the Administration For Notes of the Indicated 11/30/11 in Indicated Indicated 11/30/11 in Indicated Indica	ant #40 requested the PAP PRN medication 35 vailable 56 doses. Arders" dated 11/22/11 ge from PRN (as needed) outine order, 5/325 2 po (by mouth) ss)" The "Medication Record" in the "Nurses ed 11/29/11 at 6 p.m. out of stock and no order the to no faxed signature" The "Medication Record" in the "Nurses ed 11/30/11 at 12 a.m.			medication on hand possible need and worder from physician during rounds to pre exhausting supply o weekends.MONITO A.D.O.N. and/or desmonitor the pain me to ensure medication Medication logs will daily for 2 weeks, 3 for 8 weeks, weekly and monthly for 3 m findings will be reviemonthly QPI meeting deficient practice will addressed through seducation, in-service counseling.	will obtain in on Fridays event in RING: signee will dication logs in is available, be monitored times a week for 8 weeks, onths. All ewed at g.Any ll be staff	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUC' 00	TION	(X3) DATE S COMPL 12/12/20	ETED
NAME OF F	PROVIDER OR SUPPLIER	•			, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND RI	EHABILITATION CENTER		20 E DOUGL SHAWAKA,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EAC CROSS	PROVIDER'S PLAN OF CORRECTION TH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:00 p.m.						
	A "Nursing Note p.m. indicated, "resident. Called stated they faxed (Name)'s office to no response from A "Nursing Note p.m. indicated, "him for an order he was not doing resident was come He said it will we informed resident. The clinical record of the Administration Function and interperation buring and interperation. With Unit Methat according to Administration Function and the part of the part o	Phoned Dr. (Name) asked for Norco he stated "no git tonight" I stated appletely out of pain meds. ait until morning. I then att." In a lacked documentation attor being notified of the ag to refill Resident # 40's at the of the request. View on 12/5/11 at 5:00 Manager #28 she indicated the "Medication Record," Resident #40 ain medication, PAP 5-325, from 0 p.m. until 11/30/11 at proximately 30 hours.					
	_	o.m. she indicated that she bout getting medication					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155784	A. BUII B. WIN			12/12/2	011
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
		EHABILITATION CENTER			DOUGLAS RD VAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0501 SS=D	facility. She indiffirst time she has refill on a medical specifically remembers being her pain must that she did take medication, Tyle better pain control. Norco. She incluted Social Service expectations of her reasonable. 3.1-13(q) The facility must deserve as medical direct implementation of the coordination of the coor	for is responsible for resident care policies; and f medical care in the facility. Each and record review, the ensure the medical ted all aspects of a l care for 1 of 15 ed for proper medical of 15.	F0	501	F501lt is the practice of this facility for the Medical Director be responsible for implement of resident care policies; and coordination of medical care the facility. CORRECTIVE ACTION: Resident #40 - Resident has current order for routine and prn pain medication. Written notice set to physician/Medical Director regarding responsibilities for management of residents. In event the nursing staff get an	tation d the in or nt pain n the	01/09/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SB4V11

Facility ID:

012329 If continuation sheet

Page 69 of 73

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPI	ETED
		155784	B. WIN			12/12/2	011
			D. (VII.)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	DOUGLAS RD		
MICHIAN	NA HEAI TH AND R	REHABILITATION CENTER			WAKA, IN46545		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The clinical reco	ord of Resident #40 was			inappropriate response from		
	reviewed on 12/	06/2011 at 11:03 a.m.			physician related to resider	1t	
	Resident #40's d	liagnoses include, but			orders the nurse is to call Administrator and/or D.O.N		
		I to, HTN (hypertension),			immediately. Administrator		
		Obstructive Pulmonary			and/or D.O.N. will contact		
	`	sided heart failure, infected			physician/Medical Director.	In the	
	1 / -	·			event Adminstrator and/or I		
	1	stageable pressure sores,			are unable to get resolution		
	rhadomyolysis,	and chronic Cor			resident will be sent to the	E.R.	
	Pulmonale.				for evaluation and		
					treatment.HOW OTHERS	a i alia e	
	A "Physician's (Orders" dated 10/31/11			IDENTIFIED: Residents re		
		drocodone-APAP 5-325			in the facilty will be address notification sent to	eu by	
	1	mouth) Q6 (every 6 hours)			physician/Medical		
	for pain PRN (a	, · · · · · · · · · · · · · · · · · · ·			Director.PREVENTATIVE		
	101 paili PKN (a	s needed)			MEASURES: A.D.O.N. and	d/or	
					designee will review prn		
		n Administration Record"			medication logs on Thursda		
	dated 11/1/11 th	rough 11/10/11 indicated			each week to check the cui		
	Resident #40 red	quested the			availability and the amount		
	hydrocodone-Al	PAP PRN medication 22			medication on hand agains		
	1 -	available 40 doses.			possible need and will obta order from physician on Fri		
					during rounds to prevent	uays	
	A !!Dhygiaian!a (Oudous!! dotad 11/11/11			exhausting supply on		
	1	Orders" dated 11/11/11			weekends.MONITORING:		
	1	vdrocodone APAP 5-325			A.D.O.N. and/or designee v	will	
	"	-325 TabletGive 2			monitor the pain medication		
	tablets orally ev	ery 6 hours as needed for			to ensure medication is ava		
	pain"				Medication logs will be mor		
					daily for 2 weeks, 3 times a		
	The "Medication	n Administration Record"			for 8 weeks, weekly for 8 w and monthly for 3 months.		
		through 11/24/11			findings will be reviewed at		
		ent #40 requested the			monthly QPI meeting.Any		
		•			deficient practice will be		
	1 -	PAP PRN medication 35			addressed through staff		
	times out of an a	available 56 doses.			education, in-service, and/o	or	
					counseling.		
	A "Physician's (Orders" dated 11/22/11					
FORM CMS-2	2567(02-99) Previous Vers	ions Obsolete Event ID:	 SB4V11	Facility 1	ID: 012329 If continuation	sheet Pa	ge 70 of 73

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTI 00	ION	(X3) DATE S COMPLI 12/12/20	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STR 142	EET ADDRESS, (0 E DOUGLA 6HAWAKA, IN			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EACH CROSS-F	ROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	to a scheduled ro	5/325 2 po (by mouth)					
	PRN Notes" date "Norco 5-325 of to get in EDK du for Dr. (Name) On the back of th Administration R	Record" in the "Nurses ed 11/29/11 at 6 p.m. out of stock and no order the to no faxed signature ." The "Medication Record" in the "Nurses ed 11/30/11 at 12 a.m.					
	dated 11/30/11 in	Administration Record" ndicated the next dose of PAP 5-325 was given at					
	p.m. indicated, "I resident. Called stated they faxed primary care phy Medical Director	"dated 11/29/11 at 6:00 No Norco in stock for (Pharmacy Name). They two papers to [resident's rsician/also facility T] Dr. (Name)'s office to but no response from					
	p.m. indicated, "	" dated 11/29/11 at 7:00 Phoned Dr. (Name) ry care physician/also					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155784	B. WIN	G		12/12/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
		ELIABILITATION OFNITED			DOUGLAS RD		
MICHIAN	IA HEALTH AND R	EHABILITATION CENTER		MISHAV	NAKA, IN46545		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			COMPLETION
TAG		·		IAG	DLI ICILIAC I)		DATE
		Director] asked him for co he stated "no he was					
		ght" I stated resident was					
		of pain meds. He said it					
	resident."	orning. I then informed					
	resident.						
	During and inter	view on 12/5/11 at 5:00					
	_	Manager #28 she indicated					
	_	the "Medication					
		Record," Resident #40					
	was out of her pa						
	_	PAP 5-325, from					
		0 p.m. until 11/30/11 at					
		proximately 30 hours.					
	0.00 p.m. for up	proximately 50 nours.					
	 During an interv	riew with Resident #40 on					
	_	o.m. she indicated that she					
	_	bout getting medication					
		physician while in the					
	_	licated that this is not the					
		s had to wait over 24 for a					
		ation at this facility. She					
		embers this time due to it					
	1 -	nedication. She indicated					
		her PRN (as needed)					
		enol, but felt that she has					
	better pain control when she had her						
	Norco. She included that she is upset due						
	to Social Services telling her that her						
		ner physician were not					
	reasonable.						
	3.1-13(v)(4)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	A. BUILDING 00 COMPLET		(X3) DATE SURVEY COMPLETED 12/12/2011
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD					
MICHIANA HEALTH AND REHABILITATION CENTER MISHAWAKA, IN46545					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	